



The Institute for Family Enrichment
 615 Piikoi Street, Suite 105 • Honolulu, Hawaii 96814
 Telephone (808) 596-8433 • Fax (808) 591-1017

COLLATERAL SATISFACTION SURVEY

TIFFE Staff: _____ **Date:** _____

Which services has TIFFE been providing?

- Therapeutic Recreation Skills Trainer IISC
- Individual Counseling Family Counseling Psychiatric Services
- Assessment Intensive In-Home Therapist Intensive In-Home Para-Professional
- Other: _____

Please rate by circling your responses on a scale of 1 to 4, or "NA" if the question is not applicable.

	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4	Not Applicable NA
1. The <u>amount</u> of contact (telephone and in-person) you have had with the TIFFE staff is sufficient.	1	2	3	4	NA
2. The TIFFE staff has been professional in conducting services with you.	1	2	3	4	NA
3. The treatment/service goals set by the TIFFE staff have been consistent with the issues/goals identified in the IEP/IFSP and Mental Health Treatment Plan/Service Plan.	1	2	3	4	NA
4. The TIFFE staff has provided you with regular feedback on the child's/student's/family's progress.	1	2	3	4	NA
5. The progress that has been achieved with this child/student has been satisfactory.	1	2	3	4	NA
6. If services were <u>transitioned</u> to another TIFFE staff or level of care, the way in which the transition process was handled by TIFFE was satisfactory.	1	2	3	4	NA
Or					
If the student/child/family have been <u>discharged</u> from TIFFE services, the way in which the discharge process was handled by TIFFE was satisfactory.	1	2	3	4	NA

survey continued on back

7. Do you have any further comments about the services TIFFE provided?

8. Was there anything you think could have been done differently to improve our services?

Thank you for your time in completing this survey.

Name of Collateral: _____ **Phone No:** _____

School/Agency: _____

Name of Child/Student: _____

To be completed by TIFFE staff:

Survey completed for: Quarterly Discharge

Contract: DOE Intensive (Autism) DOE Behavioral DOE Assessment DOE Psychiatric

DOH-CAMHD EIS MST

Other: _____

Interviewer's Initials (if completed by phone): _____